STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155365	A. BUILDING 01 B. WING	05/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASH SKILLED CARE CENTER	710 N EAST ST WABASH, IN 46992

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/09/12 Facility Number: 000256 Provider Number: 155365 AIM Number: N/A Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Wabash Skilled Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility was located on the third floor of a three story building with a basement	K0000	**Wabash Skilled Care Center** **ID No. 155365** **Visit Completion Date** **5/9/2012** **ISDH Plan of Correction** **May 25, 2012** Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is June 8, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	determined to be of Type I (443) construction and the third floor was fully sprinklered. This survey will include the entire third floor due to the lack of two hour separation between the Skilled Care Center and the remaining third floor occupancy. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 25 and had a census of 12 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/15/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Drill Summary" with the Credential Specialist on 05/09/12 from 12:03 p.m. to 12:23 p.m., there was no record of a third shift fire drill for the third quarter of 2011 or a second shift fire drill for the fourth quarter of 2011. Based on an interview with the Credential Specialist at the time of record review, no other documentation was available for review to verify these drill were conducted.	K0050	K 050 NFPA 101 LIFE SAFETY CODE STANDARD It is the intent of this facility to ensure that fire drills are conducted quarterly on each shift. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The Administrator will review the fire drill schedule by 6/8/12 for the year to ensure that a drill is scheduled on each shift for each quarter. The facility will adhere to fire drill schedule to ensure compliance. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The alleged deficient practice had	06/08/2012

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	3.1-19(b) 3.1-51(c)		the potential to affect all residents. The Administrator will review the fire drill schedule by 6/8/12 for the year to ensure that a drill is scheduled on each shift for each quarter. The facility will adhere to fire drill schedule to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** The fire drill schedule will be developed annually with scheduled drills on each shift every quarter. If there is an additional fire alarm that is triggered in addition to the scheduled drill, the facility will still continue to follow the original schedule to ensure compliance. **How will the corrective action be monitored to ensure the deficient practice does not recur?** The Administrator will review the fire drill results monthly to ensure a drill is completed on each shift quarterly. **Quality Assurance Follow-up:** The fire drill records will be submitted to the Quality Assurance Committee quarterly for review to ensure compliance. **Date of Compliance:** June 8, 2012	

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K0052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure 1 of 1 center stairwell smoke detectors was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms	K0052	K 052 NFPA 101 LIFE SAFETY CODE STANDARD It is the intent of this facility to ensure that all smoke detectors pass the sensitivity test. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The Simplex model 4259-35 does not have a marked range and according to NFPA 72 the range used should be 0.5% to 4.0%. The range used on the report identified was incorrect and has been corrected. The Facilities Leader notified the Testing Company of the error on the sensitivity range. Testing Company has corrected error on reporting system to reflect the proper sensitivity range for the Simplex Smoke Detector model 4259-35. The device has been tested by the Facilities Leader with a result of 2.61%. **How will the facility identify other residents having the potential to be**	06/08/2012

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	show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect any number of occupants in the Center stairwell. Findings include: Based on record review on 05/09/12 at 12:43 p.m. with Maintenance Technician # 1 of the		**affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The Facilities Leader notified the Testing Company of the error on sensitivity range. Testing Company has corrected error on reporting system to reflect the proper sensitivity range for the Simplex Smoke Detector model 4259-35. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** The Facilities Leader will check each smoke detector sensitivity log to ensure that each detector log has the correct information listed. This will be completed by 6/8/2012. **How will the corrective action be monitored to ensure the deficient practice does not recur?** The Facilities Leader will review each fire system report monthly to ensure compliance. **Quality Assurance Follow-up:** Each fire alarm system report will be submitted to the Quality Assurance Committee quarterly for review.	

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	Automated Logic Corporation smoke detector record titled "Sensitivity Testing", the third floor smoke detector inside the Center stairwell failed the sensitivity test. Based on an interview with Maintenance Technician # 1 at the time of record review, he was unable to provide documentation to show the smoke detector had been repaired or replaced. 3.1-19(b)		**Date of Compliance: 6/8/2012**	